LEA:	 	 	

Revised 10/06

Parental Consent For Billing Public Insurance

Name of Student:		
Date of Birth:	Parent/Guardian:	
1. Health Insurance: (Ple	ease check all that apply.)	
No insurance	_ Private Insurance (Private insurance wil	I not be billed)
Sentara Family Care	dicaid Medicaid Expansion Optimum ChoiceVirginia P Chartered Health Plan	FAMIS remier
MEDICAID#		
FAMIS #		
For Medicaid Insured Only		
about my child's participation providers, the Department of Services billing agents, and an	ion: I consent for in in services billed to Medicaid to part of Medical Assistance Services, and ar ony LEA billing agent as necessary to proceed or ided for the following services as outlined	icipating physicians, other health care ny Department of Medical Assistance cess Medicaid claims for reimbursement
Type of Evaluation		Evaluation Date
Service	Service Date (from and to)	Frequency
Service	Service Date (from and to)	Frequency
Service	Service Date (from and to)	Frequency
Medications/Treatments or F provided by the parent for date	Procedures fores of service	
Medicaid coverage to seek rethese services to my child. I u	erstand my right to deny consent for the imbursement for the health-related servinderstand that my permission is voluntary to request a copy of the records disclos	ne school system to access my child's rices provided will not affect delivery or y and may be revoked at anytime. I also
Parent/Guardian Signature		Date
Name of Physician		
_		MED-5
☐ I DO NOT GIVE CONS	SENT	Developed by VDOE 4/01